DEVELOPMENTAL DISABILITIES PROGRAM: UPDATE ON EMERGING ISSUES

A Report Prepared for the
Legislative Finance Committee

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INTRODUCTION AND PURPOSE

At its March meeting, the Legislative Finance Committee (LFC) heard a report on a number of emerging issues occurring in the Developmental Disabilities (DD) System. Several options for legislative consideration were presented in the report and the LFC adopted the following two options:

1) The LFC requested that an update on the DD system be provided at each LFC meeting. The intent of this request is to allow the LFC to:
    a. Receive the most current information on a regular basis;
    b. Monitor system activity; and
    c. Provide feedback to the Department of Public Health and Human Services (DPHHS) and executive.

    Although this feedback is not binding on DPHHS it is an opportunity for the LFC to influence potential executive branch actions.
2) The LFC requested that during the 2005 legislative session the Joint Appropriations Subcommittee on Health and Human Services examine issues related to the DD system, including budgetary and public policy issues, and bring forward recommendations for consideration by the 2005 Legislature.

The purpose of this report is to provide an update on emerging issues within the DD system as requested in the option adopted by the LFC at its March 2004 meeting.

EMERGING ISSUES

This report to the LFC discusses briefly, in the sections that follow, the current status of emerging issues including:

- DD system redesign
- Travis D. litigation settlement agreement
- Medicaid redesign
- Potential decertification for Medicaid reimbursement of some institutional residents

DD SYSTEM REDESIGN

With the assistance of a contractor[1], DPHHS is in the process of significantly changing many aspects of the DD system and how it operates. The three most significant components of this redesign are:

- Development and implementation of a uniform method of allocating public resources to individuals in the DD system for the purchase of services. This new tool is known as the "MONA" (Montana Resource Allocation Protocol)
- Development and implementation of a statewide published rate structure for services purchased by the DD system
- Implementation of client "freedom of choice" to select providers and move among services or providers if they wish

Action to achieve these three components, as well as other components, is ongoing. The MONA has been developed and is in the testing phase. Some case managers have been trained in its use and it has been completed for a sample of adult services consumers. Further testing of its applicability to children receiving services is scheduled. MONA test results continue to be reviewed and necessary changes made to the tool. Additionally, the department is considering various policy options regarding which

[1] Mercer Human Services Consulting

groups of consumers the tool will be used to allocate resources. It is likely that some resources within the DD system will continue to be allocated in the same manner that has historically been used. Thus, it is possible that in some instances historical practices, which may or may not be fair and equitable, will continue to be used at this time. Currently, it is the department's plan to utilize this resource allocation tool for all individuals receiving services under the Medicaid Home and Community Based (HCBS) Waivers and those with individual cost plans that exceed $7,800. The tool will probably not be used to allocate resources for children receiving Part C Early Intervention services, since the criteria utilized within the tool may not be valid for children in this age range. At this time, an estimate of the percentage of individuals in the system that a MONA will be prepared for is not available. The contractor is scheduled to complete work related to this product by June 30, 2004.

Initial rates have been calculated and total costs under the new rate structure have been estimated. Based upon these initial rates and information obtained from providers, the contractor estimates that:

- 8 percent of the providers will experience a reimbursement decrease of 5 percent or more;
- 27 percent of the providers will experience a reimbursement increase of 5 percent or more (with 12 percent experiencing an increase of more than 10 percent); and
- More than half the providers (55 percent) will experience an increase in reimbursement between 0 to 5 percent.

The estimates, of the increases and decreases in provider reimbursement, are preliminary and will fluctuate as the draft rate schedule changes and as provider information is verified. Comments and concerns with the proposed rate structure continue to be reviewed and modifications made. Cost estimates for a sample of clients are being developed and compared to existing allocations to determine potential impacts of the reimbursement changes on consumers and providers.

The methodology for the calculation of rates differs among services. Fee for service reimbursement includes services such as: supported employment; facility based vocational services; day activity programs; residential rehabilitation; habilitation, behavioral add-ons; habilitation, medical add-ons; and supported living. Rates such as Family Education and Support Services and transportation costs are proposed as capitated rates, where a set fee per month or year would be paid regardless of the actual number of times or hours of service rendered. A rate called a "base rate" is determined for each consumer. However, the department has not yet determined exactly what items will be included in that base rate. Thus, it is difficult to estimate what "add-ons" the client may receive and how the proposed new reimbursement for a client compares to historical reimbursement levels. Lastly, the department plans to build a "risk pool" into the rate structure so that a limited amount of funds are available to address unanticipated events such as a change in a client's resource needs.

Stakeholders in the system continue to work toward consumer "freedom of choice" or portability of benefits and how this change will operate within the system. There are many policy issues, such as:

- What is the public system obligation to consumers if they wish to move to a living situation that increases the cost of their care? May the state limit the dollars allocated to a person if doing so limits the consumers ability to obtain their preferred living arrangements? If so, what rules will govern this situation?
- Providers are accustomed to having the state contract with them to serve a specified number of residents and having some flexibility within that contract to move resources from one individual to another. Under the new redesigned system, it is likely that providers will not be assured a specified number of consumers, nor will they have the flexibility to re-allocate resources from one consumer to another.

Among the issues this type of change raises are:

- How will providers deal with the risk that they may have unoccupied beds?
- How will consumer choice influence the capacity of various components within the system

While the department has indicated the redesign project would be budget neutral, there are two Executive Planning Process (EPP) requests for the 2007 biennium budget that are at least partially related to the redesign. These two requests include:

- $.4 million general fund and $.9 million total funds for 9 additional case managers so that caseloads may be reduced from the current level of 45 individuals per case manager, with 35 individuals per case manager being the preferred caseload
- $.9 million general fund and $2.1 million total funds for a 1 percent provider rate increase. Per the department this increase is necessary because no rate increase was provided in the 2003 biennium, providers' costs are increasing, and to address the disparity in rates among providers

The Governor's Office of Budget and Program Planning has not yet taken action on the department EPP submission. Thus, it is unknown whether or not these items will be included in the Governor's budget for the 2007 biennium. However, it would seem likely that discussions of a provider rate increase would occur during the 2007 legislative session. In preparation for this discussion, the LFC may wish to have the department and its contractor review, in some detail, at the next LFC meeting, the rate schedule adopted for DD services and the methodology used to arrive at these rates.

Litigation Travis D. Settlement Agreement

At its previous meeting, the LFC heard information about settlement agreement that was reached in the litigation commonly referred to as Travis D. The court ordered settlement of the Travis D. lawsuit was signed February 5, 2004. Travis D. was a class action lawsuit filed by the Montana Advocacy Program (MAP) in 1996. Defendants in this suit included the state of Montana, Montana Developmental Center (MDC), Eastern Montana Human Resources Center (Eastmont), and key personnel. This lawsuit sought to protect the civil rights of individuals with disabilities and the provision of appropriate community services for individuals with disabilities. The settlement agreement in the Travis D. litigation impacts the DD system in a multitude of areas including:

- Operation and population of the state institution
- Provision of community services to individuals with specific types of needs
- Requiring statutory and budgetary proposals be brought forward for legislative consideration
- Administration and use of the Medicaid program
- Policy and procedures for administration of the DD system
- Contracting with service providers

Planning and implementing provisions of the Travis D. settlement agreement are becoming interwoven with the day-to-day operations of the DD system. Department staff is assessing the implications of the settlement agreement on various parts of the system and projects that are underway. To date the department has begun work on items including the review of the case management functions and the independence of case managers, and training of staff. The department is maintaining a checklist of items to be completed. This checklist is updated at the end of the month.

In correspondence dated April 19, 2004, legislative legal counsel responded to a number of questions about the Travis D. settlement agreement that were posed by a member of the legislature.[2] A copy of

[2] April 19, 2004 correspondence from Gregory J. Petesch, Director of Legal Services to Representative Edith Clark.

that correspondence is attached to this report. This correspondence contains information on two types of topics, those specific to the DD system and those that also have potential cross system impacts. A brief summary of the major questions specific to the DD system discussed in this correspondence include:

- Are the terms of the settlement agreement binding upon the legislature? In part, this correspondence indicates that while the settlement agreement is worded in terms of binding the "state" the legislature is not a party to the agreement. Thus, the legislature is not bound by the terms of the agreement. However, in the event that legislative action prevents the department from fulfilling the contractual obligations outlined in the terms of the settlement agreement, further litigation might be pursued.

- May the legislature enact changes that limit eligibility, service array, service availability, and funding for the DD system? This correspondence states in part that "a settlement agreement or consent decree does not freeze the underlying statute's provisions in place" and that the Montana Constitution specifically authorizes the legislature to determine whether or not to provide social and rehabilitative services and to set rational eligibility criteria for programs and services, as well as for the duration and level of benefits and services.

- May limits be placed on the services requested by class members, such as denying services that are determined to be excessively costly under predetermined criteria? The settlement agreement appears to vest access to services for an individual within the limits of the cost plan. However, there are no provisions governing the establishment of the cost plan in statue or administrative rules. Additionally, there are a number of provisions in the settlement agreement that restrict or specify actions the department may take. The ability to limit services and deny excessively costly services appears to be possible within the constraints outlined by various provisions of the settlement agreement.

- Do provisions of the settlement agreement apply only to those individuals certified as included in the class of plaintiffs in the Travis D. litigation and if not, then to what group or groups does the settlement agreement apply? Legislative legal counsel indicates that the settlement agreement applies to any person who has been, is, or will be a resident of either of the two institutions for developmentally disabled individuals between August 23, 1996 and the date that the court preliminarily approves the settlement agreement. Furthermore, provision of services to the individuals covered by the agreement has implications for similarly situated individuals who are not covered by the settlement.

Additional detail on these topics may be obtained by reading the content of the referenced correspondence which is contained in the appendix to this document. A separate report, "Travis D. Settlement Agreement; Potential Cross-system Impacts and Implications", discusses topics that have potential impacts across systems.

Medicaid Redesign

The Medicaid redesign effort has been concluded and legislative staff received copies of the final report in early June. It is interesting to note that the Medicaid redesign advisory council did not consider or provide recommendations on policy issues related to the DD system redesign.

However, the Medicaid redesign group did provide the DD system a recommendation that they review policies on deeming of assets and cost sharing.

Potential De-certification for Medicaid reimbursement of some MDC residents

During February 2003, department staff was notified informally of the potential de-certification for Medicaid reimbursement of services to 19 individuals at MDC. In May 2004, the department was notified of the potential decertification of two additional residents at MDC. To date the department has not received formal notification of these findings and cannot appeal these findings until such formal notification is received. Department staff continues to work with the Centers for Medicare and Medicaid (CMS) and policy groups at a national level to resolve this issue.

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